REGISTRATION INTAKE FACE SHEET - ROAP

North Dakota Department of Human Services

Client Name:		Client DOB:		Client	ID:		
INTAKE INFORMATION							
ADDRESS (inclu	OTHER DEMOGRAPHICS						
		Gender	0	Male	O]	Female	
		Race (Select from Code Table)					
Home Phone Number		Ethnicity	0	Cuban	O	Mexican	
Work Phone Number		(choose only or	ne) O	Not Hispanic or Latino			
SSN			•	Other Hispanic or Latino			
Alternate Last Name			0	Puerto Rican	O 1	Unknown	
		Relation to insured (See List under Relationship in previous column)					
Age		Marital Statu	ıs O	Divorced	O	Married	
		(choose only or	ne) O	Separated	O !	Single	
			•	Unknown	· · ·	Widowed	
CLIENT INFOR	MATION						
Living Arrangement	County of Residence						
O Family Foster Care O Group/Residential Facility		Ed. Level (Select from Code Table)					
O Homeless She	elter O Jail/Correctional Facility	Language (Select from Code Table)					
O Missing	O Nursing Home	Empl. Status		abled	0	Full-Time	
O Other	O Other Institutional Setting	(choose only one	O Inn	nate Institution	•	Not applicable	
O With extended	I family O Own/Immediate Family		O Not	t working by ice	0	Part-time	
Veteran Status			O Ret	ired	0	Student	
O No	O Yes		O Une	employed			
Physician Information		Ref. Source (Select from Code Table)					
Name		Occupation (choose only one)					
Address 1		O Clerical	Worker O	Manufacturing	C g	Service Industry	
Address 2		O Craftsma	ın O	Military	O	Student	
City	State Zip	O Farmer / Rancher	O	None	O	Teacher	
		O Homema			O	Transportation	
		O Machine Operator	()	Professional / Technical	O	Unknown	
		O Manager Adminis			O		
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Client Name:		Client DOB:		Client ID:					
FINANCIAL INFORMATION	INSURAN	INSURANCE INFORMATION							
# of Dependents (REQUIRED)	Tax Year		1 st Insurance						
Monthly Income	Name								
INCOME AMOUNTS		Address							
Temporary Assistance	\$								
Wages and Salary	\$	Policy #							
Alimony or Child Support	\$		2 nd Insurance						
Veterans Benefits	\$	Name							
SSI/SSDI	\$	Address							
Other Income	\$								
TOTAL INCOME AMOUNT	\$								
EXPENSE AMOUNTS		Policy #							
Child Support Payments	(\$)	3 rd Ins	surance					
Medical Deductions	(\$) Name							
Child Care Expenses	(\$	Address							
Alimony Paid	(\$)							
TOTAL EXPENSE AMOUNT	(\$	Policy #							
Net Monthly Adjusted Gross Income	MA	O No O	Yes #:						
Income Verified O Yes	Not verified:								
Responsible Party Information									
Name		SSN							
Address			Home Phone Number						
		Work Phon							
Employer	page)	Occupation (See List on previous page)							
I understand that a discount of(Ending Date), and I am	(enter discount perce			(Effective Date) to					
I hereby apply for services from the North I				information as required to assist					
the Center in determining eligibility for serv		ormation. This in	formation may inclu	de the hilling and collection					
I have received a copy of the Center's supplemental admission information. This information may include the billing and collection procedures, the fee schedule, and the client appeals process. The policies and procedures contained within that document have been									
explained to me and I agree to follow them for all the services correctly billed to me by the Human Service Center.									
I understand that if my insurance company does not pay in full, I am financially responsible, based on the above discount. I hereby certify that the above statements are true and correct to the best of my knowledge.									
I understand that if any information is willfully withheld the FULL FEE for any services provided will be charged.									
Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose this information will not affect this application.									
information will not affect this application.									
Client's Signature	Date	Parent / Leg	al Guardian Signature	 Date					